Indiana State Department of Health

INDIANA STATE DEPARTMENT OF HEALTH
SICKLE CELL ANEMIA PROGRAM
PROPHYLACTIC PENCILLIN ORDER

State Form 42517 (R / 4-99) / SBH27-153-23

CONFIDENTIALITY STATEMENT: All information which would permit identification of an individual will be held confidential pursuant to 42 CFR 51a.112 and IC 5-14-3-4(a)(3) and will not be divulged without the individual's consent except as may be necessary to provide services to individual mothers and children. Information may be disclosed in a summary or statistical form which does not identify particular individuals.

Please check one: ☐ Initial Request ☐ Reorder Date of request (*month, day, year*): _____ / _____ / _____

Name of patient _____ Address: _____

County of residence _____ Date of birth (*month, day, year*): _____ / _____ / _____ Sex: ☐ M ☐ F

Race / Ethnic group: (*check one*) ☐ Black ☐ White ☐ Hispanic ☐ Italian ☐ Greek ☐ Turkish
☐ Sicilian ☐ Arabian ☐ Asian Indian ☐ Southeast Asian ☐ Other

Date of diagnosis of Sickle Cell Anemia **(ATTACH LAB REPORT ON INITIAL REQUEST):** _____

Name of Physician requesting penicillin: _____

Telephone number: (_____) _____

City / state / ZIP code _____

QUANTITY		PENICILLIN V POTASSIUM	QUANTITY		EYTHROMYCIN
	Bottles	125 mg powder for oral solution in 100 ml bottles		Bottles	EES 200 mg granules for oral suspension in 100 ml bottles
	Bottles	250 mg powder for oral solution in 100 ml bottles			
	Bottles	250 mg tablets in bottles of 100		Bottles	E sterate 250 mg tablets in bottles of 100

PLEASE ORDER 3 MONTHS SUPPLY. NEW ORDER FORM MUST BE SUBMITTED EACH QUARTER. SUPPLY WILL BE SHIPPED ON A QUARTERLY BASIS

Please mail your order to:
Indiana State Department of Health
Maternal and Child Health
Newborn Screening Section -7C
2 North Meridian Street
Indianapolis, IN 46204

Telephone: 317 / 233-1254

FOR INTERNAL USE ONLY

1. Date form received:
2. Date logged in:
3. Date order shipped:
4. Order filled by:
5. Newborn screening number: